change of ownership. (The merger of another corporation into the center corporation does not constitute change of ownership.)

(3) *Leasing.* The lease of all or part of an entity constitutes a change of ownership of the leased portion.

(b) *Notice to CMS.* A center which is contemplating or negotiating change of ownership must notify CMS.

(c) *Assignment of agreement.* When there is a change of ownership as specified in paragraph (a) of this section, the agreement with the existing center is automatically assigned to the new owner if it continues to meet the conditions to be a Federally qualified health center.

(d) *Conditions that apply to assigned agreements.* An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, the following:

(1) Compliance with applicable health and safety standards.

(2) Compliance with the ownership and financial interest disclosure requirements of part 420, subpart C of this subchapter.

§ 405.2446 Scope of services.

(a) For purposes of this section, the terms *rural health clinic* and *clinic* when they appear in the cross references in paragraph (b) of this section also mean Federally qualified health centers.

(b) FQHC services that are paid for under this subpart are outpatient services that include the following:

(1) Physician services specified in § 405.2412.

(2) Services and supplies furnished as an incident to a physician's professional services, as specified in § 405.2413.

(3) Nurse practitioner or physician assistant services specified in § 405.2414.

(4) Services and supplies furnished as an incident to a nurse practitioner or physician assistant services, as specified in § 405.2415.

(5) Clinical psychologist and clinical social worker services specified in § 405.2450.

(6) Services and supplies furnished as an incident to a clinical psychologist or clinical social worker services, as specified in § 405.2452.

(7) Visiting nurse services specified in § 405.2416.

(8) Nurse-midwife services specified in § 405.2401.

(9) Preventive primary services specified in § 405.2448 of this subpart.

(10) Medical nutrition therapy services as specified in part 410, subpart G of this chapter, and diabetes outpatient self-management training services as specified in part 410, subpart H of this chapter.

(c) Federally qualified health center services are covered when provided in outpatient settings only, including a patient's place of residence, which may be a skilled nursing facility or a nursing facility or other institution used as a patient's home.

(d) Federally qualified health center services are not covered in a hospital, as defined in section 1861(e)(1) of the Act.

[57 FR 24979, June 12, 1992, as amended at 61 FR 14657, Apr. 3, 1996; 71 FR 69782, Dec. 1, 2006]

§ 405.2448 Preventive primary services.

(a) Preventive primary services are those health services that—

(1) A center is required to provide as preventive primary health services under section 329, 330, and 340 of the Public Health Service Act;

(2) Are furnished by or under the direct supervision of a nurse practitioner, physician assistant, nurse midwife, specialized nurse practitioner, clinical psychologist, clinical social worker, or a physician;

(3) In the case of a service, are furnished by a member of the center's health care staff who is an employee of the center or by a physician under arrangements with the center; and

(4) Except as specifically provided in section 1861(s) of the Act, include only drugs and biologicals that cannot be self-administered.

(b) Preventive primary services which may be paid for when provided by Federally qualified health centers are the following:

(1) Medical social services.

(2) Nutritional assessment and referral.

(3) Preventive health education.

(4) Children's eye and ear examinations.
(5) Prenatal and post-partum care.
(6) Perinatal services.
(7) Well child care, including periodic screening.
(8) Immunizations, including tetanus-diptheria booster and influenza vaccine.
(9) Voluntary family planning services.
(10) Taking patient history.
(11) Blood pressure measurement.
(12) Weight.
(13) Physical examination targeted to risk.
(14) Visual acuity screening.
(15) Hearing screening.
(16) Cholesterol screening.
(17) Stool testing for occult blood.
(18) Dipstick urinalysis.
(19) Risk assessment and initial counseling regarding risks.
(20) Tuberculosis testing for high risk patients.
(21) For women only.
(i) Clinical breast exam.
(ii) Referral for mammography; and
(iii) Thyroid function test.

(c) Preventive primary services do not include group or mass information programs, health education classes, or group education activities, including media productions and publications.

(d) Screening mammography is not considered a Federally qualified health center service, but may be provided at a Federally qualified health center if the center meets the requirements applicable to that service specified in §410.34 of this subchapter. Payment is made under applicable Medicare requirements.

(e) Preventive primary services do not include eyeglasses, hearing aids, or preventive dental services.

[57 FR 24980, June 12, 1992, as amended at 61 FR 14657, Apr. 3, 1996]

§ 405.2449 Preventive services.

For services furnished on or after January 1, 2011, preventive services covered under the Medicare Federally qualified health center benefit are those preventive services defined in section 1861(ddd)(3) of the Act, and §410.2 of this chapter. Specifically, these include the following:

(a) The specific services currently listed in section 1861(ww)(2) of the Act, with the explicit exclusion of electrocardiograms.

(b) The Initial Preventive Physical Examination (IPPE) (as specified by section 1861(ww)(1) of the Act as added by section 611 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108–173) and §410.16 of this chapter); and

(c) The Personalized Prevention Plan Services (PPPS), also known as the ''Annual Wellness Visit'' (as specified by section 1861(hhh) of the Act as added by section 4103 of the Affordable Care Act (Pub. L. 111–148) and §410.15 of this chapter).

[75 FR 73613, Nov. 29, 2010]

§ 405.2450 Clinical psychologist and clinical social worker services.

(a) For clinical psychologist or clinical social worker professional services to be payable under this subpart, the services must be—

(1) Furnished by an individual who owns, is employed by, or furnishes services under contract to the FQHC;

(2) Of a type that the clinical psychologist or clinical social worker who furnishes the services is legally permitted to perform by the State in which the service is furnished;

(3) Performed by a clinical social worker or clinical psychologist who is legally authorized to perform such services under State law or the State regulatory mechanism provided by the law of the State in which such services are performed; and

(4) Covered if furnished by a physician.

(b) If State law prescribes a physician supervision requirement, it is met if the conditions specified in §491.8(b) of this chapter and any pertinent requirements of State law are satisfied.

(c) The services of clinical psychologists or clinical social workers are not covered if State law or regulations require that the services be performed under a physician's order and no such order was prepared.

[57 FR 24980, June 12, 1992, as amended at 61 FR 14657, Apr. 3, 1996]